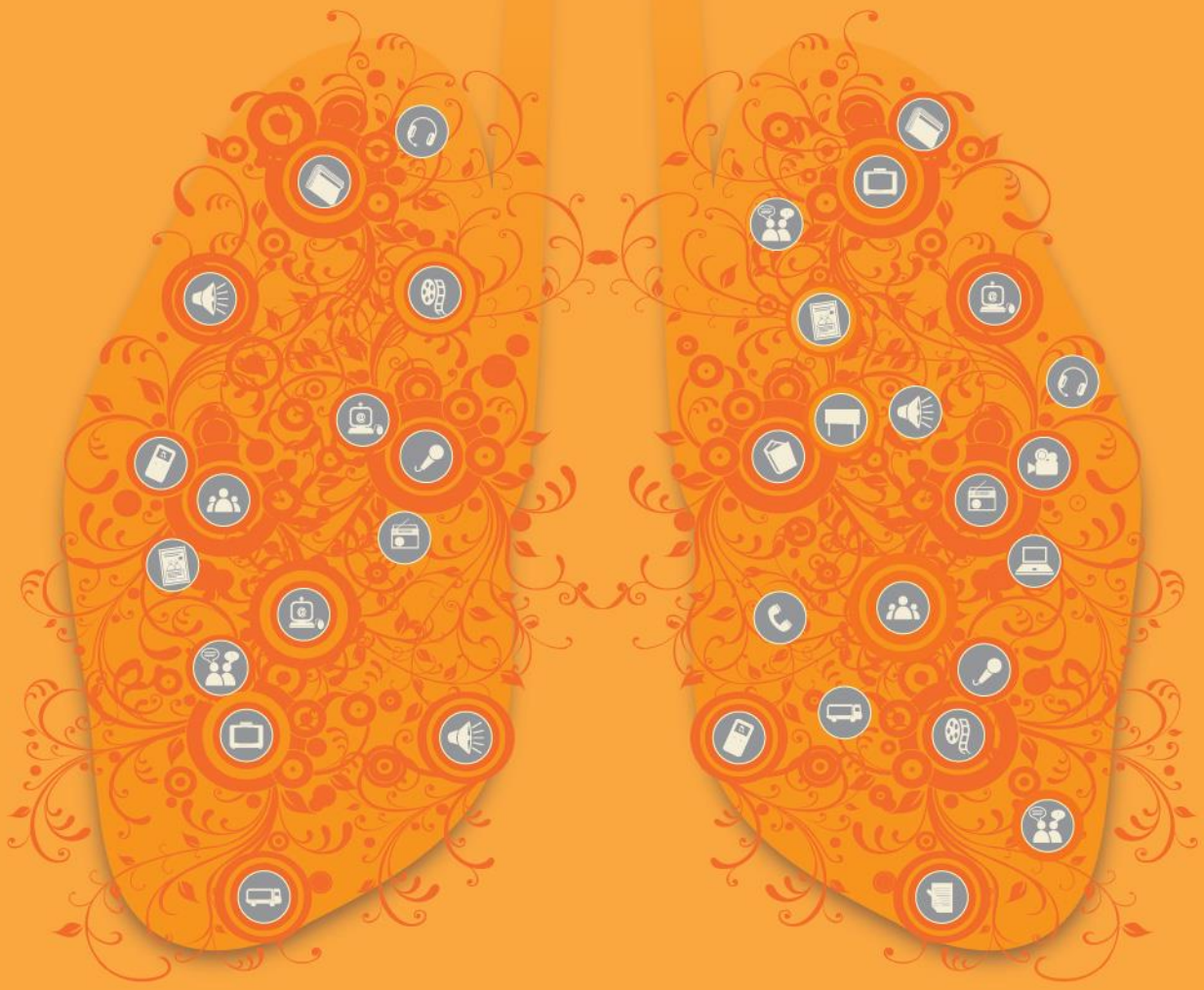
ACSM STATUS REPORT

Ministry of Health
and Family Welfare
Government of India

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

A Status Report on the Advocacy Communication and Social Mobiiization (ACSM) in Revised National Tuberculosis Program



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Foreword

The Revised National Tuberculosis Control Program (RNTCP) continues to step forward with the renewed objective of 'Universal access to early quality diagnosis and quality of TB care for all TB patients'. Advocacy, communication, and social mobilization (ACSM) remains a strong inbuilt component of RNTCP to improve visibility, reach, awareness, and effectiveness of TB control initiatives at the community and provider level and is critical to the opinion leaders and policy makers.

The National Strategic Plan 2012-2017 also highlights the ACSM strategy to complement every other programme initiatives to achieve universal access. The vision is a multi-level, multi-stakeholder ACSM strategy that spans the full spectrum from national to state, district, sub-district and the community at large complement various programme components

Before moving forward with this new vision of "National Strategic Plan 2012-2017" there was a need to relook at the existing ACSM strategy and understand the status of ACSM implementation in the country during 11th five year plan. This report is a result of the efforts made by a team from 'Improving Health Behaviours Program (IHBP)' in collaboration with Central TB Division, Ministry of Health and Family Welfare with financial support from USAID.

The report analyses the current status of ACSM implementation and identifies the key challenges in designing, planning, implementing and monitoring ACSM activities. It also suggests possible steps to address these challenges. The report indicates that the Revised National Tuberculosis Control Program (RNTCP) has made several efforts in strengthening its ACSM activities in the country. There has been provision of support from partners in strengthening ACSM. Several capacity building activities of RNTCP staff have also been undertaken.

The report is timely useful asset to carry forward our work of ACSM strategy under National strategic plan with renewed energy. I express my gratitude and congratulation to IHBP on this endeavour and effort.

Place: New Delhi

Date: 26th November 2013

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Preface

Tuberculosis (TB) is a major health challenge for India. The Revised National Tuberculosis Control Programme (RNTCP), using the internationally recommended Directly Observed Treatment Short Course (DOTS), is being implemented across the country under the guidance and direction of the Central TB Division (CTD). Significant progress has been made in providing treatment to TB patients and checking the spread of TB infection. Nonetheless, the problem is becoming more serious, with drug resistance, TB/HIV co-infection, and other associated risk factors emerging as the new challenges facing TB control and eradication.

The RNTCP has a strong advocacy, communication, and social mobilization (ACSM) component that is vital to the program's success. Seeking to revisit its ACSM strategy, CTD requested the U.S. Agency for International Development (USAID)-supported FHI 360 Improving Healthy Behaviors Program (IHBP) to undertake a snapshot study of how ACSM activities are being planned, implemented, and monitored at state and district levels. The study was designed to identify key challenges and how they could be addressed to make RNTCP implementation more effective.

This report, the outcome of the snapshot study, is a joint effort of many professionals associated with the study and reflects their contributions, and I would like to take this opportunity to thank them. First of all, I must thank Dr. R.S. Gupta, Deputy Director General & Project Director (RNTCP), CTD; Dr. Neeraj Kulshrestha, Additional Deputy Director General TB; and his senior colleagues for entrusting this study to IHBP and providing support at all stages. Special thanks to Ms. Moni Sinha Sagar, Contracting Officer Representative, USAID/New Delhi, for her continued support and guidance to the project. I am grateful to the ACSM consultants and senior officials associated with the RNTCP in the selected states, especially the State Tuberculosis Officers; State Information, Education, and Communication (IEC) Officers; District Tuberculosis Officers; RNTCP consultants; and the nongovernmental organizations associated with ACSM activities, for sharing the data and their experiences.

I thank my former colleagues Mr. Sumit Asthana, Mr. Amit Paliwal, and Mr. Maju Mathew of IHBP, and Ms. Beth Haytmanek of USAID for their inputs during planning stage and field study.

I would also like to extend my gratitude to Mr. Shiva Shrestha and Dr. Satish Kaipilayar from PATH for technical support during the field study and also for providing their valuable comments and suggestions during the preparation of this report. Sincere thanks to Dr. Subhash Yadav for critically reviewing the draft report and giving valuable comments and suggestions.

Sincere thanks to Mr. Sunil Verma, Chief Technical Advisor-IS, and Ms. Tara Appachu Sharma, Deputy Chief of the Party, for overall supervision and coordination of the study results.

Finally, I would like to thank Dr. J.S. Yadav, the key consultant, for preparing study tools, collecting field data, and preparing the draft report as well as the final report, after incorporating the suggestions received from other experts.

Dr. Rita Leavell
Chief of the Party
Improving Healthy Behavior Programs (IHBP)

Abbreviations and Acronyms

ACSM	Advocacy, Communication, and Social Mobilization
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
CBCI	Catholic Bishops Conference of India
CBNAAT	Cartridge-Based Nucleic Acid Amplification Testing
CHAI	Catholic Health Association of India
CMAI	Christian Medical Association of India
CTD	Central TB Division
DFID	Department for International Development
DMC	Designated Microscopy Center
DOTS	Directly Observed Treatment Short Course
DRTB	Drug-Resistant Tuberculosis
DTC	District Tuberculosis Center
DTO	District Tuberculosis Officer
FGD	Focus Group Discussion
GOI	Government of India
HIV	Human Immunodeficiency Virus
IDI	In-Depth Interview
IEC	Information, Education, and Communication
IHBP	Improving Healthy Behaviors Program
IMA	Indian Medical Association
IPC	Interpersonal Communication
M&E	Monitoring and Evaluation
MDR	Multi-Drug-Resistant
MLA	Member of the Legislative Assembly
MO	Medical Officer
MOTC	Medical Officer-Tuberculosis Control
MOU	Memorandum of Understanding
NGO	Nongovernmental Organization
NRHM	National Rural Health Mission
NSP	New Sputum Positive
NTP	National Tuberculosis Programme
PIP	Program Implementation Plan
PLHIV	People Living with HIV
PP	Private Practitioner
PPM	Public-Private Mix
PRI	Panchayati Raj Institution
PSI	Population Services International
PWB	Patient-Wise Box
RNTCP	Revised National Tuberculosis Control Programme
STLS	Senior TB Laboratory Supervisor
STO	State Tuberculosis Officer
STS	Senior Treatment Supervisor
TB	Tuberculosis
TU	Tuberculosis Unit
The Union	International Union Against Tuberculosis and Lung Disease
UP	Uttar Pradesh
USAID	U.S. Agency for International Development
WHO	World Health Organization

Executive Summary

Background

Tuberculosis (TB) is a major public health problem in India. Almost 40 percent of Indians have latent TB, which means they are not infectious but carry the risk of developing active TB. India accounts for one-fifth of global TB cases. Each year nearly 1.8 million Indians develop TB, of whom about 800,000 are infectious. Annually, about 370,000 people die of TB in India, almost 1,000 deaths every day or two deaths every 3 minutes. Other than health concerns, TB is also associated with social stigma and fear. Men and women infected with TB have to deal with stigma and discrimination at their workplaces, in their communities, and even in their households.

In response to the country's TB situation, the Revised National Tuberculosis Control Programme (RNTCP), based on the internationally recommended Directly Observed Treatment Short Course (DOTS) strategy, was formally launched in 1997 and was expanded across the country in a phased manner, with support from the World Bank and other development partners. The RNTCP has a nationwide administrative and organizational structure, with the Central TB Division (CTD) as the national-level body that guides the activities through various state-level units. The RNTCP has successfully established more than 2,700 Tuberculosis Units (TUs) and more than 13,000 Designated Microscopy Centers (DMCs) in 662 RNTCP districts. Each year a network of more than 600,000 trained DOTS providers throughout the country provide DOTS to more than 1.5 million patients diagnosed with TB.

Advocacy, communication, and social mobilization (ACSM) is a strong component of the RNTCP, supporting it with guidelines for preparing state plans, strategizing, and implementing ACSM activities with the support of partner organizations. There is need for a revised ACSM strategy to address current challenges and emerging issues. To this end, CTD requested the U.S. Agency for International Development (USAID)-supported FHI 360 Improving Healthy Behaviors Program (IHBP) to undertake a snapshot study of how ACSM activities are planned, implemented, and monitored at state and district levels. IHBP was also asked to identify challenges in planning and implementing ACSM and how these challenges can be addressed.

Objectives of the Study

The three specific objectives of the study were to:

1. Assess the status of ACSM activities at state and district levels, focusing on implementation against planned activities
2. Identify challenges in planning, designing, implementing, and monitoring ACSM activities

- Document promising practices on ACSM, lessons, and initiatives

Five states—Bihar, Gujarat, Karnataka, Meghalaya, and Uttar Pradesh (UP)—were selected for the field study based on performance (case detection rate) and geographical representation.

A checklist of semi-structured "probe" questions was prepared to cover different areas/issues in planning and ACSM. This study tool was prepared for use with concerned officials at center, state, and district levels in in-depth interviews (IDIs), along with focus group discussions (FGDs) and observations.

Field visits to the selected states and districts for data collection were undertaken during the last week of February and the third week of April 2013.

Key Findings

Human Resources

The State Tuberculosis Officer (STO); State Information, Education, and Communication (IEC) Officer; District Tuberculosis Officer (DTO); and Communication Facilitators are the key functionaries of the RNTCP. Frequent transfers of STOs and DTOs adversely affect the program. For example, in UP, an IEC Officer had not been appointed for the last few months; the one before had stayed in the position for less than a year.

At the time of the study, the STOs in Bihar and UP were new in their positions and not well versed with ACSM or even the RNTCP. Similarly, the DTOs in Begusarai (Bihar), Azamgarh (UP), and West Khasi Hills-Nongstoin (Meghalaya) were relatively new and not very knowledgeable about the concept of ACSM or the program's ACSM activities.

The position of Communication Facilitator, though important, was in disarray. The position was vacant in some states. Some staffers who had joined as Communication Facilitators within the last year or so had left their jobs as they found their remuneration low and their workload overwhelming, with too many responsibilities and too much travelling required to cover the expected 5–7 districts.

Continuity of tenures and commitment to the RNTCP are essential for effective implementation of various ACSM activities. High commitment and team spirit were clearly noticeable in Gujarat, Karnataka, and Meghalaya (in that order), reflected in their documentation and program implementation. The situation was quite different in Bihar and even more so in UP, adversely affecting program performance.

Recommendations

1. There is need for both induction and refresher ACSM training courses for all the officers under the RNCTP. The officers themselves emphasized the need for ACSM training. The content of trainings should aim for conceptual clarity about ACSM and make specific work plans with measurable outcomes linked to RNTCP objectives.
2. The global ACSM curriculum should be customized to the Indian context. The training should focus on conceptual understanding of ACSM, strengths and weaknesses of different channels of communication for TB control, and their specific roles in strengthening ACSM.
3. A key ACSM functionary, the State IEC Officer, operates on a temporary contractual appointment for the project and has to deal with STOs, DTOs, and other senior officials of the health system and the administration. Besides being professionally sound, the job requires the position holder to tactfully handle senior officers to proactively push the ACSM agenda. This necessitates developing and sharpening the State IEC Officers' public relation skills.

- Remunerations for Communication Facilitators should be made more attractive and their area of operation more manageable, perhaps 2–3 districts instead the present 6–7 districts. The terms of reference for the position should focus on planning and implementing district-level ACSM activities, facilitating quality village meetings and making them more effective, and following up with TB *mitras* over the phone and through visits.

Planning and Budget Allocation

The states prepare their annual ACSM program implementation plan (PIP) with budget allocations on the basis of the broad guidelines issued by CTD under the RNTCP and use the given template. First, the district ACSM action plans are prepared by the district TUs; these plans are subsequently discussed and consolidated into state action plans. The key step here is to identify the three main

program challenges that ACSM seeks to tackle during the year. The ACSM action plan template lists the key communication questions: for whom is the plan being prepared, what ACSM activities/materials are needed, by when (time frame) is the plan needed, who is responsible for implementing the plan, how is the plan going to be monitored and evaluated, and what is the budget for each ACSM activity. Additionally, the relation of the whole activity to program objectives and their linkage to outcomes is important.

All five of the participating states had diligently completed their ACSM templates, as it was a CTD requirement for approval and release of funds under the RNTCP. However, a closer look at PIPs showed lack of clarity. Whatever the specific program challenges were in each state, the ACSM activities/media materials were broadly similar. Further, there was confusion over program challenges and ACSM objectives.

A common refrain in discussions with the concerned staff was that the budget for ACSM was very small and was released only toward the last months of the year, making it difficult to organize ACSM activities within the planned time frame.

Recommendations

1. There is a felt need for increasing budget allocations in view of the rising prices, particularly of petrol because it affects mobility, and for increasing and expanding ACSM activities. Equally important is the timely release of the approved budget, with the first installment being released in the first quarter itself so that ACSM activities can be executed as planned.
2. The officers involved in preparation of PIPs and the annual action plans—State IEC Officers, DTOs, and Accounts Officers—must be trained to develop a strong understanding of the ACSM planning template.
3. Need- and evidence-based planning is required for optimal utilization of the ACSM budget, for which the health care workers at district and state levels must be trained. Participation of other stakeholders, including nongovernmental organizations (NGOs), must be encouraged to leverage support for ACSM activities.
4. Gujarat is a great case study on collaborative effort and integration: RNTCP activities are conducted in collaboration with the National Rural Health Mission (NRHM) and joint IEC activities are conducted.
5. A joint ACSM plan to address all aspects of TB, multi-drug-resistant (MDR) TB, and TB/HIV co-infection should be developed, instead of a piecemeal approach to ACSM planning.

Advocacy

The terms “advocacy,” “communication,” and “social mobilization” are often used interchangeably by the ACSM staff. Conceptual clarity about advocacy and its role and significance in TB control was lacking among most ACSM officials. Little was being done by way of policy advocacy, program advocacy, media advocacy, and advocacy with the corporate world in Bihar, Karnataka, Meghalaya, and UP. Attempts were being made in Gujarat, but they require further strengthening.

Except in Gujarat, not much had been done elsewhere for advocacy with elected representatives at national, state, and community/village levels.

Recommendations

1. A series of short sensitization workshops should be organized for senior administrators; media professionals, from both news and program divisions; and corporate leaders to secure greater administrative support, play the role of a force multiplier in awareness generation, and increase funding from private sources to give the RNTCP a boost.
2. Large *chintan shivirs* (congregations of elected representatives of the Panchayat), along the lines of the Gujarat model, should be organized for elected representatives of state assemblies and village panchayats. The *chintan shivirs* in Gujarat may be video documented for wider dissemination and adoption after adaptation to local context by other states.
3. Additionally, a series of workshops for village Sarpanches may be organized on a smaller scale at the block level.
4. Advocacy activities should be clearly spelled out in state ACSM plans and should target the existing barriers to ensure that the RNTCP gets strong commitment and support from all sectors, including politicians, bureaucrats, and the media.

Communication

Communication is an overarching process that unfolds on mass media channels like newspapers, radio, television, and films; mid-media like posters, hoardings, wall writings, leaflets, pamphlets, and folk forms of entertainment; interpersonal communication (IPC) one on one; and group meetings.

Under the RNTCP, a series of messages about TB is being disseminated to the public using different media and channels of communication. These messages seek to inform the public about the services that exist for diagnosis and treatment and include the following: *"If you have a cough for more than two weeks, go for diagnosis"*; *"If you are found to be TB positive, seek treatment"*; *"TB is curable"*; and *"Opt for DOTS for sure and complete cure."*

The TV and radio spots for *Bulgam Bhai*, a collaborative effort of CTD, Project Axshya, BBC World Trust, and Population Services International (PSI), have been quite popular and form a well-recalled TB awareness mass media campaign.

Recommendations

1. The program requires more nationwide campaigns like *Bulgam Bhai*, each focusing on one key issue. The four key messages that the future campaigns could focus on include:
   - TB is curable, it is like any other disease, and anyone can fall prey to TB bacteria. (Such messages would address the stigma associated with TB.)
   - DOTS is a sure cure for TB, and stopping medicines in between can lead to the serious problem of DRTB.
   - Under RNTCP DOTS, the diagnosis and all the medicines are free. The same diagnosis would cost a lot if done with a private doctor/facility. The free medicines under DOTS are not of poor quality or spurious. They are the most effective medicines for completely curing TB.
   - Indiscriminate use of antibiotics and other medicines can lead to drug resistance. (A general message along these lines should be sent out under NRHM.)
2. The same message should be sent out through mass media, mid-media, IPC, and other support communication materials for greater synergy and effect.

3. Communication messages must be developed in local languages at the state and district levels.
4. Refresher trainings in IPC and counseling skills must be conducted.
5. There is a need to develop different toolkits to address specific challenges and priorities of different groups.

Social Mobilization

Social mobilization is the process of bringing together different sections of a targeted population, for example, a village community or ward, to raise awareness of and demand for the TB control program. The emphasis here is on community participation and involvement in TB detection and cure.

Social mobilization generates dialogue, negotiation, and consensus, engaging a range of players in interrelated and complementary efforts. Under the RNTCP, the partner NGOs play an important role in social/community mobilization.

Social mobilization activities include group and community meetings, school activities, traditional media group performances, rallies, and road shows. IPC and group communication are the main channels of communication for disseminating key TB-related messages. Leaflets, posters, pamphlets, videos, and other communication aids in local language/dialects are often used to make communication contextual and comprehensible for the local community. Media materials like leaflets and pamphlets are often given to take home for repeated exposure.

The *chintan shivirs* in Gujarat, organized on the Chief Minister's initiative, are a large, regional-level social mobilization exercise, bringing together the elected representatives of Panchayati Raj Institutions (PRIs). Village meetings and patient-service provider meetings, and in some cases the development of district TB forums, are the main social mobilization activities under the RNTCP; these are being organized as per CTD norms.

It is on World TB Day, March 24, that most social mobilization activities under ACSM action plans take place in all five states, both in capital cities and districts. A fresh set of posters and flexi banners is readied, and a number of activities and events are organized to create awareness about the TB programs under the RNTCP, especially highlighting the achievements of the previous year. These include rallies, functions, painting competitions, and school activities. VIPs are invited to such events and prizes are distributed. Miking (public announcements) is done around the city, broadcasting the activities under the RNTCP for creating awareness about TB control. However, more important than the number of such meetings/activities is their actual quality and efficacy. Our observation and discussions suggest that there is scope for substantial improvement in that area.

Recommendations

1. More soft skills training workshops, focused on IPC, group dynamics, and group communication, should be organized for all those associated with the tasks of community mobilization and organizing village meetings and patient-service provider meetings. These workshops should cover counseling and the conduct of group meetings, among others.
2. A noteworthy suggestion was made during an FGD in Begusarai, Bihar, namely, that the teams going to villages for community mobilization should be provided with a dress designed to look like the TB program logo. The team members wearing it would not only draw the attention of everyone in the community, but would also help in establishing the brand of the program. Provision of a megaphone for the teams would also increase the level of attention

they draw and allow them to reach out to a greater number of villagers with TB control messages.

Involvement of Private Practitioners

The private health practitioners operating in the villages, often called *jholla chhap/Bengali doctors*, are the first level of contact for most people in villages and smaller towns, especially for those from the poorer sections of society. People prefer to first go to them for any ailment, as they provide easy and timely access and quick first-level care, offer assuring communication, and hear out the problems of their patients. However, the treatment they provide can provide only initial relief to TB patients, and may not cure TB.

Instead of the injections and the "handful of medicines" to be consumed on alternate days under the DOTS regime, which cause reactions like acidity and "heat" that many patients find difficult to bear, the private practitioners (PPs) give more bearable daily doses. As a result, some TB patients stop adhering to the DOTS regime and switch to private practitioners. Moreover, the comfort level of patients is much higher with private doctors than with government doctors and health providers. Government health facilities are difficult to access even during normal office hours, and remain altogether closed at other times. People leave for work early in the morning and return late in the evening, by which time the government facilities are closed.

The involvement of private practitioners is thus a must for the success of the program. In fact, cooperation of all health providers, private and government, is necessary to cover and refer all TB suspect cases for proper diagnosis and DOTS treatment.

Recommendations

1. There is a need to advocate with private doctors' associations like the Indian Medical Association (IMA), especially with the local state/district branches, and sensitize them about the importance of the TB control program and the significance of their role in it.
2. A scheme/mechanism of incentives must be devised to at least partly mitigate the loss of business private practitioners would suffer by referring all suspect cases and providing treatment only under DOTS.
3. Referral and notification systems and procedures need to be made easier to follow and less time consuming for all health practitioners.
4. Based on the specific needs of districts/states, an ACSM plan for private sector participation should be developed.
5. Currently, the participation of the private sector is limited to the NGO/PP scheme,[1] which itself is not motivating for private providers. The new strategic plan should provide more avenues for private sector participation. ACSM should thus play a complementary role to promote private sector participation in the program that goes beyond the public-private mix (PPM) schemes.

Monitoring and Evaluation of ACSM

There is no well-designed mechanism or system to assess the impact of ACSM activities under the RNTCP. Generally, the number of activities organized is itself taken as "proof" of ACSM success.

[1] NGO/PP schemes are RNTCP-developed schemes designed to foster partnership with various private sector providers, including hospitals, health care facilities, diagnostic facilities, NGOs, and community-based organizations. Currently there are ten schemes implemented by RNTCP.

Monitoring of ACSM activities is thus limited to reporting in output indicators, for example, number of community meetings conducted. It must be remembered, though, that **ACSM activities are not an end in and of themselves, but only a means to increase case detection and adherence to DOTS.**

Recommendations

1. There is a need to design a system whereby, in a given time frame, any increase in the number of symptomatic TB suspect cases referred to/reporting for diagnosis at DMCs could be linked with the date of the organization of ACSM activities.
2. Operational guidelines need to be prepared for monitoring and evaluation (M&E) of different ACSM activities by measurable indicators.
3. M&E of ACSM activities should be part of ACSM trainings.

Promising Innovations/Practices to Support ACSM

1. **SETCOM – Direct link with frontline workers and the community.** In Gujarat, on the third Thursday of every month, between 2pm and 4pm, more than 6,000 villages are reached via direct link SETCOM. On average, 36,000 accredited social health activists (ASHAs)/health workers/anganwadi workers (AWWs)/members of Village Health and Sanitation Committees are provided technical information on select issues by subject specialists. The topics include TB, malaria, tobacco, maternal health, school health, and family welfare. State-level program managers address frontline workers and minimize their doubts through question-and-answer sessions.
2. **ACSM activities in Gujarat are supported by the Health Education Bureau,** thus addressing the problem of low budget and coordination. This is a good approach to increase coordination with NRHM.
3. Gujarat has adopted the practice of signing memorandums of understanding (MOUs) with a local NGO to hire Communication Facilitators. This reduces the time it takes to hire Communication Facilitators in the case of attrition of contractual staff.
4. Gujarat uses the free online messaging services of Way2SMS to report MDR TB patients diagnosed in six districts. Though the service is currently working on a pilot basis and used for cartridge-based nucleic acid amplification testing (CBNAAT) diagnosis technology, it promises good results and could be used in referral and diagnosis of normal TB cases as well.

Way Forward

The emergence of MDR TB, TB/HIV co-infection, and increasing cases of diabetes are posing new and serious challenges for the RNTCP. The program should make strategic plans to provide universal access, that is, to detect at least 90 percent of all types of TB cases and ensure successful treatment of at least 90 percent new cases and at least 85 percent of previously treated cases. Some approaches to work toward this goal could be:

1. Involve communication specialists to strengthen and lead ACSM strategic planning at national and state levels, provide support across the RNTCP network, and work closely with NRHM communication stakeholders
2. Focus the ACSM planning format on state and district-level priorities and use output/outcome monitoring indicators for different ACSM activities
3. Concentrate on achieving universal awareness of the right to and availability of free TB treatment and care through mass media and mid-media

4. Bolster social mobilization for TB detection and DOTS adherence through PRIs and other community-based organizations like self-help groups and health and sanitation committees
5. Prioritize IPC approaches at the TU level and below; enhance provider communications targeted at different categories of patients so that the right message reaches the right person at the right time

ACSM activities should now focus on preventing the emergence of MDR TB through effective communication and counseling of TB patients for good DOTS adherence. Advocacy with and capacity development of care providers by improving their motivation and counseling skills can go a long way toward tackling the problem of TB in India.

1. The ACSM Study

1.1 Background

TB is an infectious disease caused by mycobacteria, usually *Mycobacterium tuberculosis*, that typically attacks lungs but can also affect other body organs. It spreads through air when an infected person coughs. Hitherto known as a poor man's disease, TB affects people across geographies and socioeconomic boundaries.

TB continues to remain a major public health problem in India. India accounts for 26% of all the TB cases globally with 2 -2.5 million cases reported in the year 2011.Approximately, 31% of the estimated missing 2.9 million TB cases globally live in India.[2] Almost 40 percent Indians have latent TB; they're not infectious but carry the risk of having the infection develop into active TB. It is estimated that approximately 370,000 Indians die every year from TB with two deaths every three minutes The number of maternal deaths from TB is also significantly higher that other causes of maternal mortality.

TB in India is a ticking bomb.
Two deaths occur every three minutes as a result of TB.

In 2012, a total of 7,867,194 TB suspects were examined for sputum smear microscopy, and 1,467,585 cases were started on treatment. The case detection rate of new smear positive TB cases stood at 68 percent, with treatment success rate of 88 percent. As per the Revised National TB Control Programme (RNTCP) Annual Report 2013, it is estimated that 10% of total TB load is found in children. The number of paediatric TB cases registered under RNTCP has shown an increasing trend in the past five years and in 2012, about 81,482 cases were notified. However the actual burden of childhood TB (globally as well as in India) could be much higher because TB in children often goes undiagnosed. Further, 821,807 (56 percent) TB patients were tested for HIV and 44,063 (5 percent) were found to be HIV positive. About 92 percent of HIV-infected TB patients were initiated on co-trimoxazole prevention therapy CPT and 59 percent were initiated on anti-retroviral therapy (ART).[3]Apart from its health impacts, TB is also associated with social stigma and fear in India. The affected have to deal with stigma at their workplaces, in their neighborhoods and communities, and even in their households. Even matrimonial alliances become difficult if it becomes public that the girl/boy or even a member in the family has TB.

The emergence of MDR TB has become a serious global health issue in recent years. High detection rates of MDR TB in many cities, e.g., Mumbai, highlights the gravity of the situation in India. It is estimated that India has the highest number of DRTB patients in the world with 64,000 cases[4].

Unhygienic habits of coughing and sneezing without covering the nose/face with a handkerchief increase the chances of healthy persons contracting TB infection. Cramped living conditions with 5–6 or even more persons in a small room, in urban slums and among rural poor provide a favorable environment for the spread of TB infection.

[2] Global Tuberculosis Report 2013, WHO, http://apps.who.int/iris/bitstream/10665/91355/1/9789241564656_eng.pdf
[3] TB country profile preview for India http://www.who.int/tb/publications/global_report/gtbr13_annex_2_country_profiles.pdf
[4] Global Tuberculosis report 2011, http://apps.who.int/iris/bitstream/10665/44728/1/9789241564380_eng.pdf

1.2 TB Control Programs in India

India's National Tuberculosis Programme (NTP) has been in place since 1962. However, the treatment success rates were low and the death and default rates remained high. In view of this, in 1992, the Government of India (GOI), with the World Health Organization (WHO) and the Swedish International Development Cooperation Agency, reviewed the TB situation and concluded that:

- NTP, though technically sound, suffered from managerial weaknesses
- NTP was funded inadequately
- NTP relied too heavily on x-rays for diagnosis
- There were frequent interruptions in the supplies of drugs
- There were low rates of treatment completion

To overcome these problems, in 1993, the GOI decided to give a new thrust to TB control by revitalizing NTP with assistance from international agencies. This was the basis for the establishment of the RNTCP, which adopted the internationally recommended DOTS strategy as the most systematic and cost-effective approach to control TB in India.

The RNTCP was formally launched in 1997 and expanded across the country in a phased manner with support from the World Bank and other development partners.

The evolution and progress of TB eradication in India have been aligned with global efforts. The RNTCP is in line with WHO's Stop TB Strategy (2006–2015) in addressing TB/HIV and MDR TB, involving private practitioners, and encouraging public-private partnerships. It has a detailed M&E process with guidelines, tools, and reporting formats at all levels.

The objectives of RNTCP are:

- Achieve and maintain cure rate of at least 85 percent among new sputum positive (NSP) patients
- Achieve and maintain case detection of at least 70 percent of the estimated NSP cases in the community

This is reflective of a marked shift to a quantitative and target-based approach at the strategic and policy levels. The RNTCP achieved NSP case detection rate of more than 70 percent and treatment success rate of greater than 85 percent in 2007; it has been committed to maintaining these global targets for TB control since then.

The RNTCP has a strong administrative and organizational structure, with CTD as the national-level body that guides/regulates program activities through various state-level units. It has successfully established more than 2,700 TUs and more than 13,000 DMCs in 662 RNTCP districts to date. A network of more than 600,000 trained DOTS providers throughout the country provide DOTS to more than 1.5 million patients diagnosed with TB each year.

To further strengthen TB eradication efforts and create a "TB-free India," the National Strategic Plan for the years 2012–2017 has been drafted. The GOI aims to reduce the burden of disease until it is no longer a major public health problem. To achieve this vision, the RNTCP is now aiming for universal access to quality diagnosis and treatment to all TB patients in the community. This objective entails sustaining the achievements of the program to date and extending the reach and quality of services to all people diagnosed with TB.

With the GOI vision as the long-term guide, the program's defined objectives for 2012–2017 are:

1. Ensure early and improved diagnosis of all TB patients, including those with drug-resistant TB (DRTB) and those with TB/HIV
2. Provide access to high-quality treatment for all diagnosed cases of TB
3. Scale up access to effective treatment for DRTB
4. Decrease the morbidity and mortality of HIV-associated TB
5. Extend RNTCP services to patients diagnosed and treated in the private sector

The RNTCP defines the overarching guidelines and processes to be followed in all phases of TB control and prevention, starting with multiple channels of identifying a suspect, followed by diagnosis of TB by conducting appropriate lab tests, putting on DOTS treatment, adherence, and monitoring.

Suspect identification involves creating mass awareness and seeking the support and involvement of various public health stakeholders, including government doctors, health workers, ASHAs, auxiliary nurse midwives, private physicians, specialists, chemists, and rural practitioners. These stakeholders disseminate information about the TB diagnosis and treatment process and motivate suspects to visit public or private sector labs for the appropriate test. Various incentive schemes have been devised for health workers, NGOs, private practitioners, and others to encourage stakeholders to actively identify suspects.

Diagnosis of TB involves sputum collection, transportation, microscopic lab examination, and reporting of results within 72 hours of sample collection. A key goal of the RNTCP is to ensure that all symptomatic suspects diagnosed as TB positive are registered as TB patients for treatment.

Treatment for TB: After diagnosis and registration, trained public DOTS providers put all TB patients on DOTS treatment as per RNTCP guidelines. Regular follow-up visits, treatment adherence, and patient monitoring are the responsibility of all stakeholders, especially the DOTS providers. Adherence to DOTS treatment is the key to a successful TB cure.

Quality-assured, anti-TB drugs for the full course of treatment are provided free of cost to patients through individual boxes that are earmarked for each patient, so that once a patient starts treatment there is no shortage throughout the course of treatment. Decentralized treatment is provided through a network of about 700,000 DOTS providers to make treatment available to patients close to their homes. Utilization of pediatric patient-wise boxes (PWBs) is on the rise since their introduction in 2006; these boxes are designed according to the dosages used for different weight bands of pediatric patients.

The RNTCP has involved more than 1,971 NGOs and 10,894 private practitioners. An impressive 150 corporate hospitals and 297 medical colleges are implementing the RNTCP. The program has forged successful partnerships with IMA, the Catholic Bishop Conference of India (CBCI), PATH, the International Union Against Tuberculosis and Lung Disease (The Union), and World Vision/India.

1.3 ACSM

1.3.1 ACSM in TB Control

ACSM is necessary to increase the visibility, reach, awareness, and effectiveness for TB control programs and activities among policymakers, opinion leaders, and the community. The RNTCP recognizes the importance of a comprehensive ACSM strategy as a guiding document for preparing state plans, strategizing, and implementing ACSM activities. Many efforts are being made at the state, district, and TU levels through the RNTCP ACSM strategy and other partners, including the civil

society-run Project Axshya ("TB free"), to address ACSM challenges and support TB control programs and activities.

Project Axshya adds a new dimension to TB control in India through community ownership and civil society-led public health programming. The project is funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria as part of its larger Round 9 TB grant to India. The GOI, The Union, and World Vision/India are the three principal recipients of the grant. It is an ambitious ACSM project, with The Union component covering 374 districts across 23 states and union territories in India to reach about 570 million people.[5]

[5] Project Axshya http://www.theunion.org/what-we-do/technical-assistance/tuberculosis-and-mdr-tb/project-axshya

2. The ACSM Status Study

There is need for a revised ACSM strategy to address the current challenges and emerging issues and to align it with the National Strategic Plan (2012–2017). In view of this, CTD assigned IHBP to undertake a snapshot study of how ACSM activities are being planned, implemented, and monitored at state and district levels. The study was to also examine challenges to ACSM in the RNTCP and to recommend ways of addressing these challenges.

2.1 Objectives of the Study

The specific objectives of the study were to:

1. Assess the status of ACSM activities at state and district levels, focusing on implementation
2. Identify challenges in planning, designing, implementing, and monitoring ACSM activities
3. Document promising practices on ACSM, lessons learned, and other ACSM initiatives

2.2 Field Study Areas

The following five states were selected for field data collection and observation:

1. Bihar
2. Gujarat
3. Karnataka
4. Meghalaya
5. Uttar Pradesh

These states were selected for the study on the basis of "case notification" and geographical representation. After arranging the 32 states and Union Territories in descending order on annual smear positive case notification rate (Reference: Annual Report 2012), the list of states was categorized as less than 50 percent, less than 60 percent, and less than 85 percent. Two states were selected from less than the 50 percent category, and one state was selected from each of the other two categories. The five selected states were chosen as geographically representative of regions (east, west, north, northeast, and south) in the country. Among these five states, four—Bihar, Karnataka, Meghalaya, and UP—are also Project Axshya states.

Table 1. Key Performance Indicators of State/District Profile

S. No.	State/district	Population	Annualized smear positive case notification rate from CFR	Cure rate (%)
1	Gujarat	60,383,628	83	87.8
1.1	District – Surender Nagar	1,755,873	81	87.0
2	Bihar	103,804,637	39	80.4
2.1	District – Begusarai	2,954,367	41	68.0
3	Uttar Pradesh	199,581,477	86	71.0
3.1	District – Azamgarh	4,616,509	61	85.0
4	Karnataka	61,130,704	61	81.2
4.1	District – Tumkur	2,681,449	70	84.0
4.2	District – Davangere	1,946,905	59	74.0
5	Meghalaya	2,964,007	71	81.5
5.1	West Khasi Hills	385,601	67	82.0

Source: TB Annual Report 2012.

2.3 Methodology

A checklist of semi-structured "probe" questions was prepared to cover different areas, like planning, advocacy, communication, and social mobilization, through IDIs with concerned officials at center, state, and district levels. These questions were pretested with RNTCP officials at the state level in Delhi before using them in the selected states for data collection through IDIs, FGDs, and observations.

Probe

Questions were posed to cover a specific area of inquiry. The people being interviewed were probed further by asking supplementary questions on related points and also on the basis of his/her responses.

In-Depth Interviews

Key officials of the RNTCP at the national level were interviewed, including the Chief Medical Officer (Additional Deputy Director General) and ACSM consultant.

In each of the selected states, senior state-level officials concerned with TB control were interviewed on the basis of the semi-structured interview schedule. These included:

1. STOs
2. State-level medical consultant for the RNTCP
3. TB IEC Officers
4. The media agency working/handling TB publicity/IEC campaign
5. The NGO partner working in TB control (ACSM and PPM)
6. The ACSM consultant (partner)

In each state, a district was identified in consultation with the STO for district-level field data collection. The following officers were interviewed at the district level:

1. The DTO
2. The District IEC Officer
3. The Medical Officer-Tuberculosis Control (MOTC)
4. The Senior Treatment Supervisor (STS)
5. The Communication Facilitator
6. The partner NGO, community-based organization

Ethical Considerations

Ethical issues were addressed by obtaining informed consent from participants. The following steps were taken and explained to the participants before the interview:

1. Confidentiality of participants and their responses will be maintained; no responses will be linked with names
2. Participation in the study is voluntary
3. Responses will be accessed by limited people for research and report writing only

3. Key Findings and Observations

3.1 Human Resources

CTD has set norms and guidelines for ACSM human resources at state and district levels. Within the NRHM and State Health Society framework, the RNTCP has been provided the required staff for diagnosis and treatment of TB. The STOs and DTOs are regular health staff (doctors) from the state health department. The State IEC Officers and the Communication Facilitators are project staff, the state health/medical consultants are from WHO, the ACSM consultants come from Project Axshya, and the STS and Senior TB Laboratory Supervisor (STLS) are again RNTCP project staff from the main partner NGO or the network NGOs.

Our study found that the STOs and DTOs were in position in all the five states, but only the STOs in Gujarat and Karnataka had participated in one of the four ACSM sensitization and capacity building workshops organized by CTD under the RNTCP in 2011. The others had taken charge as STO/DTO more recently. The STOs in Bihar, Meghalaya, and UP had recently taken charge at the time of our visit and were not formally trained on the RNTCP and ACSM. Similarly, the DTOs of Begusarai in Bihar, Azamgarh in UP, and West Khasi Hills-Nongstoin in Meghalaya were relatively new and had little awareness of the RNTCP in general and ACSM in particular.

Frequent transfers of these officers adversely affect the RNTCP. In UP, the STO had been in position for just a few months. A day after meeting him during the field study, we found out that he had been transferred and a new STO had taken charge. In UP, the State IEC Officer post has been vacant for the last few months, and we were told that a new person is likely to join soon. The key informant mentioned (without our asking) that the new appointee was a relative of the state health minister.

Frequent transfers of STOs, DTOs, and ACSM staff adversely affect the implementation of the RNTCP.

Induction and refresher courses on ACSM should be organized frequently for RNTCP staff.

Further, the STOs and DTOs are not full-time on the RNTCP, but rather have additional responsibilities that do not allow them to pay full attention to the RNTCP.

Nonetheless, the DTOs of Tumkur district, Karnataka, and Surender Nagar district, Gujarat, were enthusiastic about their responsibilities regarding controlling TB. High team spirit was particularly noticeable in Tumkur. There, the local NGO is headed by a retired DTO from Tumkur itself. He has a good understanding of the program and is zealously moving its agenda forward. He has also documented all the ACSM activities undertaken in the last few years, with photographs of village meetings and dates and brief write-ups on each such activity. However, the present DTO of Tumkur is due for transfer, which might affect the RNTCP work in the district.

Our discussions with STOs, State IEC Officers, and DTOs strongly pointed to the following:

1. Both induction and refresher ACSM trainings must be organized for all the officers under the RNCTP. The staff themselves emphasized the need for ACSM training.
2. Continuity of tenures and commitment are critical for effective and successful implementation of various ACSM activities under the RNTCP. Strong commitment and team spirit were clearly noticeable in Gujarat, Karnataka, and Meghalaya (in that order), reflected in

documentation and program implementation. The situation was quite different in UP and Bihar (more so in UP), adversely affecting program performance.

3. The State IEC Officer is the key ACSM functionary. The position operates on a temporary contractual basis for the project and has to deal with STOs, DTOs, and other senior officials of the health system and the administration. This requires that State IEC Officers not only be professionally sound, but also have the public relations skills to tactfully handle senior officers to push the ACSM agenda proactively and forcefully.

Communication Facilitators

There is provision in the RNTCP for appointing a few Communication Facilitators in each state. However, this position was vacant in many places. Our team could meet only some Communication Facilitators during the course of the field study. From the discussions, it emerged that the Communication Facilitators' terms of reference are not clear or well defined, remunerations are low, and the job requires more travelling than is practically possible. Each Communication Facilitator is expected to cover 6–7 districts.

Even so, a Communication Facilitator we met in Surender Nagar district in Gujarat was most enthusiastic and doing well in covering six districts. He believes his role to be that of a "troubleshooter" and goes to where a "problem" is reported. The following case studies illustrate the point he was making and strongly highlight the importance of Communication Facilitators.

Case Study 1

In Gujarat's Khera district, one of the six districts the Communication Facilitator covers, low case detection was reported during a monthly meeting with the STO and DTOs on February 13, 2013. The meeting was attended by the STS, the STLS, and TB/HIV service and some DOTS providers. There it was agreed that village meetings would be organized in the 4–5 identified villages to increase case reporting/referral. These meetings were announced in advance and organized on the fixed dates. About 50–60 people participated in each meeting; the participants included 1–2 patients, 1–2 cured patients, DOTS provider, ASHAs, AWWs, 2–3 members of the partner NGO, self-help groups, elected present/past members of the village Panchayat, and 30–40 other villagers, both men and women. The Facilitator was not sure about the participation of weaker sections like Scheduled Caste/Scheduled Tribe and the Muslim minority community. The meetings were addressed by the Communication Facilitator, who provided information about TB as a disease and its symptoms, diagnosis, and cure by DOTS. This was followed by some queries from villagers, which the Communication Facilitator and his colleagues (DOTS provider and STLS) answered.

Case Study 2

In another case, it was reported that a TB patient was put on DOTS, but he stopped taking the medicines. Despite the DOTS provider's best efforts, he refused to take the medicines, complaining that the medicines caused him *garmi* (heat) and so he "cannot digest these medicines." The Communication Facilitator visited the patient a few times but to no avail. He then identified his network of friends in the village and explained to them that the medicines were absolutely necessary for the patient and that they should persuade him to resume treatment. The Communication Facilitator's strategy worked and the patient began taking the medicines. Unfortunately, though, the patient had already become drug resistant and died after six months or so.

The discussion also brought up several other cases of patients' initial non-adherence to the DOTS regime and subsequent resumption and successful completion of treatment after interventions by the

RNTCP staff in different states. Some of these may be documented in detail and shared widely to inspire both TB patients and service providers.

Case Study 3

In another case, a TB patient was taking his medicines regularly but not getting sufficient nutrition because of his poor economic condition. The Communication Facilitator approached a well-off businessman and appealed to him for some charity in the form of food for the TB patient. The businessman agreed and provided food not only for that one TB patient but also for all other needy TB patients in the city.

These case studies highlight the Communication Facilitator's initiative and how the different situations were handled, with the convergence of efforts of both health workers and the community itself. At the ground level, the Communication Facilitator triggers and facilitates this convergence of effort.

Note: The Communication Facilitator works closely with community health workers to address communication needs, capacity building, message content development, delivery, and follow-up for results of communication. Case-finding, treatment initiation, defaulter tracing, and adherence are all community health worker responsibilities. However, in reality, there is an overlap, and ACSM training is required for all RNTCP field-level staff to gain better conceptual understanding of ACSM and skills to perform their respective roles more effectively. It is also required to convey the point that communication activities are not an end unto themselves, but only a means to end TB.

3.2 Planning and Budget Allocation

The states prepare their PIPs in accordance with the broad guidelines issued by CTD under the RNTCP. A comprehensive template has been devised by CTD for the ACSM component. Each state prepares the annual action plan for ACSM activities along with budget allocations. First, the district ACSM action plans are prepared by the district TUs, which are then discussed at the state level and consolidated into the state action plan. The key issue here is to identify three main program challenges that ACSM would tackle during the year. The ACSM template lists the key communication questions: for whom is the plan being prepared, what ACSM activities/materials are needed, by when (time frame) is the plan needed, who is responsible for implementing the plan, how is the plan going to be monitored and evaluated, and what is the budget for each ACSM activity.

All five of the states under study had diligently completed the ACSM templates, as that is a CTD requirement for approval and release of the funds under the RNTCP. However, a closer look at the PIPs reflects lack of clarity; whatever the program challenges in each state were, the ACSM activities/media materials were broadly similar.

Discussions with STOs, State IEC Officers, DTOs, and other concerned officers in the five states pointed to the lack of conceptual understanding about ACSM. Most equated ACSM with IEC or just publicity. Furthermore, there was no clarity as to how ACSM efficacy could be monitored and evaluated. The organization of ACSM activities was seen as an end in itself. This could have resulted from the fact that most STOs, DTOs, and even State IEC Officers (except the State IEC Officers in Bihar, Gujarat, and Karnataka) had not been trained in ACSM.

Although four national/regional-level ACSM capacity building workshops for key field-level functionaries were held under the RNTCP in 2011, of the presently posted staff in the five states, only two State IEC Officers (Bihar and Gujarat) and one STO (Karnataka) participated in these workshops.

The other currently posted STOs, State IEC Officers, and DTOs did not attend any capacity building workshop on ACSM.

Table 2. State ACSM Budgets

S. No.	State	Budget (Indian rupees)		
		2010–2011	2011–2012	2012–2013
1.	Gujarat	6,176,391	6,758,790	6,839,200
2.	Bihar	3,630,000	4,663,000	7,120,000
3.	Uttar Pradesh	–	–	–
4.	Karnataka	2,300,000	2,408,000	3,5 45,000
5.	Meghalaya	1,807,680	1,198,815	1,399,880

There are stated norms for the allocation of the central budget to states under the RNTCP, based on the population size and the number of districts; there is a 10 percent increase over the previous year's budget utilization and some additional provisions for northeastern states like Meghalaya. A common refrain in discussions with all the concerned staff was that the budget for ACSM was insufficient and that it was released only toward the last months of the year, making it difficult to organize ACSM activities within the planned time frame.

However, the TB program in Gujarat had the ability to draw money on loan from the State Health IEC budget under NRHM, enabling it to carry on with its planned ACSM/IEC activities. On the other hand, the situation in UP was a difficult one. During 2011–2012, no money was released for the state in view of the state NRHM scam[6] and some pending audit objections. In the current year (2012–2013), money was received as late as February. The concerned officers at both state and district levels expressed their apprehension about utilizing the money. They would rather let it lapse than spend it in March 2013 and invite audit questions and vigilance inquiries.

Notwithstanding PIPs and annual action plans, the majority of activities under ACSM are organized for World TB Day (March 24). For most of the year, the RNTCP keeps its focus on medical issues (diagnosis and treatment of TB) and IPC between service providers and TB patients.

3.3 Advocacy

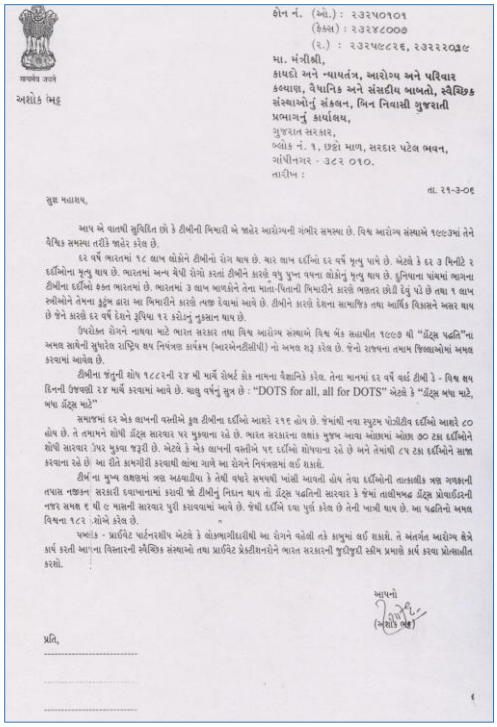
TB advocacy denotes activities to impress upon influencers and decision makers the benefit of making TB a more central part of the public health agenda and to seek support for creating an enabling environment for the TB control program. Advocacy fosters political will, increases financial and other resources on a sustainable basis, and holds authorities accountable to ensure that pledges are fulfilled and results achieved. Advocacy can be discussed under three broad themes:

- Policy advocacy involves advocacy with senior politicians and administrators on the impact of the issue at the national level and the need for action.
- Program advocacy works at the local, community level to convince opinion leaders about the need for local action.
- Media advocacy seeks to generate support from governments and donors, validate the relevance of a subject, put issues onto the public agenda, and encourage the media to cover TB-related issues regularly and in a responsible manner, thereby creating a more favorable environment for individual and community action to control TB.

[6] http://en.wikipedia.org/wiki/Uttar_Pradesh_NRHM_scam accessed on 14th March 2014

None of the states covered in the field study had undertaken any policy advocacy or media advocacy for TB control. No workshops had been organized for the political leadership of the states. One positive instance was that the Gujarat Health Minister had written to members of the Legislative Assembly (MLAs) and other political leaders in the state about TB and sought their cooperation and support for the TB control program.

Not much has been done so far by way of advocacy with policymakers (political leadership and bureaucracy) except through official circulars. No sensitization/orientation workshops for members of parliament/MLAs or senior administrators were reported from the five states under study.



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અશોક ભટ્ટ

મા. મંત્રીશ્રી,
કાયદો અને ન્યાયતંત્ર, આરોગ્ય અને પરિવાર કલ્યાણ, વૈધાનિક અને સંસદીય બાબતો, સ્વૈચ્છિક સંસ્થાઓનું સંકલન, બિન નિવાસી ગુજરાતી પ્રભાગનું કાર્યાલય,
ગુજરાત સરકાર,
બ્લોક નં. ૧, છઠ્ઠો માળ, સરદાર પટેલ ભવન,
ગાંધીનગર - ૩૮૨ ૦૧૦.
તારીખ :

તા. ૨૧-૩-૦૬

સુજ્ઞ મહાશય,

આપ એ વાતથી સુવિદિત છો કે ટીબીની બિમારી એ જાહેર આરોગ્યની ગંભીર સમસ્યા છે. વિશ્વ આરોગ્ય સંસ્થાએ ૧૯૯૩માં તેને વૈશ્વિક સમસ્યા તરીકે જાહેર કરેલ છે.

૬૨ વર્ષે ભારતમાં ૧૮ લાખ લોકોને ટીબીનો રોગ થાય છે. ચાર લાખ દર્દીઓ ૬૨ વર્ષે મૃત્યુ પામે છે. એટલે કે ૬૨ ૩ મિનીટે ૨ દર્દીઓના મૃત્યુ થાય છે. ભારતમાં અન્ય યેપી રોગો કરતા ટીબીને કારણે વધુ પુખ્ત વયના લોકોનું મૃત્યુ થાય છે. દુનિયાના ચોથમાં ભાગના ટીબીના દર્દીઓ એકલા ભારતમાં છે. ભારતમા ૩ લાખ બાળકોને તેના માતા-પિતાની બિમારીને કારણે ભણતર છોડી દેવું પડે છે તથા ૧ લાખ સ્ત્રીઓને તેમના કુટુંબ દ્વારા આ બિમારીને કારણે ત્યક્ત કેવામા આવે છે. ટીબીને કારણે કેંદાના સામાજિક તથા આર્થિક વિકાસને અસર થાય છે જેને કારણે ૬૨ વર્ષે દેશને રૂપિયા ૧૨ કરોડનું નુકસાન થાય છે.

ઉપરોક્ત રોગને નાથવા માટે ભારત સરકાર તથા વિશ્વ આરોગ્ય સંસ્થાએ વિશ્વ બેંક સ્થાપીત ૧૯૯૩ થી "ડોટ્સ પદ્ધતિ"ના અમલ સાથેની સુધારેલ રાષ્ટ્રિય ક્ષય નિયંત્રણ કાર્યક્રમ (આરએનટીસીપી) નો અમલ કરે કરેલ છે. જેનો રાજ્યના તમામ જિલ્લાઓમાં અમલ કરવામાં આવેલ છે.

ટીબીના જંતુની શોધ ૧૮૮૨ની ૨૪ મી માર્ચે રોબર્ટ કોચ નામના વૈજ્ઞાનિકે કરેલ. તેના માનમાં ૬૨ વર્ષે વર્લ્ડ ટીબી ડે - વિશ્વ ક્ષય દિનની ઉજવણી ૨૪ માર્ચે કરવામાં આવે છે. ચાલુ વર્ષનું સુત્ર છે : "DOTS for all, all for DOTS" એટલે કે "ડોટ્સ બધા માટે, બધા ડોટ્સ માટે"

સમાજમાં દર એક લાખની વસ્તીએ કુલ ટીબીના દર્દીઓ આશરે ૨૧૬ હોય છે. જેમાંથી નવા સ્પુટમ પોઝીટીવ દર્દીઓ આશરે ૮૦ હોય છે. તે તમામને શોધી ડોટ્સ સારવાર પર મુકવાના રહે છે. ભારત સરકારના લક્ષાંક મુજબ આવા ઓછામાં ઓછા ૭૦ ટકા દર્દીઓને શોધી સારવાર ઉપર મુકવા જરૂરી છે. એટલે કે એક લાખની વસ્તીમાં ૫૬ દર્દીઓ શોધવાના રહે છે અને તેમાંથી ૮૫ ટકા દર્દીઓને સાજા કરવાના રહે છે. આ રીતે કામગીરી કરવાથી લાંબા ગાળે આ રોગને નિયંત્રણમાં લઈ શકાશે.

ટીબીના મુખ્ય લક્ષણમાં ત્રણ અઠવાડીયા કે તેથી વધારે સમયથી ખાંસી આવતી હોય તેવા દર્દીઓની લાલલાઈક ત્રણ ગણકની તપાસ નજીકના સરકારી દવાખાનામાં કરાવી જો ટીબીનું નિદાન થાય તો ડોટ્સ પદ્ધતિની સારવાર કે જેમાં લાલીબ્લીસ્ટર ડોટ્સ પ્રોવાઈડરની નજર સમક્ષ ૬ થી ૯ માસની સારવાર પુરી કરાવવામાં આવે છે. જેથી દર્દીને રોગ પુર્ણ કરેલ છે તેની ખાત્રી થાય છે. આ પદ્ધતિનો અમલ વિશ્વના ૧૮૨ દેશોમાં કરેલ છે.

પબ્લીક - પ્રાઈવેટ પાર્ટનરશીપ એટલે કે લોકભાગીદારીથી આ રોગને ઘટાડી તો કાબુમાં લઈ શકાશે. તે અંતર્ગત આરોગ્ય ક્ષેત્રે કાર્ય કરતી આપના વિસ્તારની સ્વૈચ્છિક સંસ્થાઓ તથા પ્રાઈવેટ પ્રેક્ટીશનરોને ભારત સરકારની જુથીજુથી સ્કીમ પ્રમાણે કાર્ય કરવા પ્રોત્સાહીત કરશો.

આપનો
(અશોક ભટ્ટ)

પ્રતિ,
.....
.....
.....

An appeal letter in Gujarati signed by the **Hon'ble HM** circulated to all **MLAs, Presidents of Zilla and Taluka Panchayats** of the state to improve the political commitment to the program at the root level among the districts.

No special sensitization workshops had been organized for senior administrators in the government. Only through official circulars and personal briefings was information about the RNTCP shared with the concerned senior administrators. Neither were there any special sensitization workshops on TB control for media persons. The only media advocacy-related activities were the usual press conferences/briefings and issuing of press releases.

However, activities have been organized for program advocacy, particularly in Gujarat. Every year the Gujarat Chief Minister's office organizes two *chintan shivirs*, with participation of about 500–700 Sarpanches/panches. These *sammelans/shivirs* focus on the development programs and initiatives of the state government. The Chief Minister has been addressing these gatherings, which are also attended by concerned ministers, MLAs, and officials. Exhibitions on development themes are organized, and representatives from the media cover these events. The state RNTCP has been utilizing these *chintan shivirs* for publicity by putting up stalls on the TB control program and activities, disseminating publicity materials, and providing checkups and counseling to visitors. According to

the IEC Officer, these *shivirs* have been a great success and a large number of people have been visiting the stalls set up by the RNTCP.

The Chief Minister of Gujarat visiting the TB control stall set up at a *chintan shivir.*

3.4 Communication

3.4.1 Communication as an Overarching Theme

Communication is a *process* people use to exchange information through channels like mass media, community media, and IPC. Much of the communication effort on TB is concerned with *transmitting* a series of messages to the people affected by TB. But for communication to be effective, "participation" and "dialogue" are equally necessary.

Within the overarching term "communication," there are three linked, overlapping, and complementary communication threads: program communication, advocacy, and social mobilization. Also, the terms "IEC," "behavior change communication," and "ACSM" are used interchangeably by field staff.

3.4.2 Program Communication to Inform and Empower

The purpose of program communication is to create awareness and empower people to take action. Under the RNTCP, a series of messages about TB are being disseminated to the public through different media and channels of communication. These messages include: *"If you have a cough for more than two weeks, go for diagnosis"*; "*If you are found to be TB positive, seek treatment"*; "*TB is curable"*; "*Opt for DOTS for sure and complete cure."* Additionally, the public is being informed about what services exist for diagnosis and treatment.

At the national level, CTD is responsible for designing appropriate messages and disseminating them on appropriate channels of communication. CTD has made a number of short films, TV and radio spots, posters, banners, and other publicity materials as part of its campaign to control TB and make a "TB-free India." The short films include: *Atoot Dor* and *Chaar Kahaniya*, and the TV and radio spots are: *Nayi Bahu, Do Kahaniyan, Adhoori Hajaamadt*, and *Adhoori Mehndi*.

The TV and radio spots for *Bulgam Bhai*, a collaborative effort of CTD, Project Axshya, BBC World Trust, and PSI, have been a popular and well-recalled TB awareness campaign. The imaginary comical character asks in a funny way to any individual who is coughing: "*Do hafte ho gaye kya?"* (*Has it been there for more than two weeks?*). At the end, the character advises people who have had

cough for more than two weeks to visit DMCs of the RNTCP for sputum microscopy. In appearance the character looks urban and healthy, perhaps to convey the message that TB can attack wealthy, urban people as well; it is not just a poor man's disease.

Bulgam Bhai flexi boards and posters were visible in all the state and district TB hospitals/facilities. The State IEC Officers, STOs, and DTOs claimed that *Bulgam Bhai* was a very popular character and was being used extensively in all outreach programs like the *chintan shivirs* in Gujarat, in village-level awareness meetings, and at DOTS centers. Notably, the use of other short films seemed to be negligible, as the officers did not mention these films on their own and during probe. They were either unaware of these short films or not enthusiastic about them.

More nationwide campaigns like *Bulgam Bhai* are needed, each focusing on one key issue. The four key messages that future campaigns could focus on include:

- TB is curable, it is like any other disease, and anyone can fall prey to the TB bacteria.
- DOTS is a sure cure for TB, and incomplete treatment can lead to the serious problem of DRTB.
- Under RNTCP DOTS, the diagnosis and medicines are completely free. (Taken at a private facility, the treatment could cost lakhs[7] of rupees.)
- Indiscriminate use of antibiotics and other medicines can lead to drug resistance. (A general message along these lines should be sent out under NRHM.)

The same message should be sent out on mass media, mid-media, IPC, and the support communication materials for greater synergy and effect.

CTD has developed 23 exhibit materials on TB, covering all the program components of the RNTCP, including DOTS, DRTB, TB/HIV, and TB-diabetes. These are being utilized to disseminate key messages on TB and the program among the general population.

In the states, TV and radio spots were broadcast in state languages except in the state of Meghalaya. The posters and banners were also printed in local languages. The flexi banner on *Bulgam Bhai* was put up in all state RNTCP offices and government TB hospital premises. However, we could not locate any posters, banners, or hoardings/billboards in the city outside the government TB facilities.

TB is curable. DOTS is a sure cure for TB. Treatment under DOTS is completely free.

TB is like any other disease. Anyone can be attacked by the TB bacteria.

Irregular treatment can lead to the serious problem of DRTB.

[7] 1 lakh= 100,000

Flexi boards and wall posters at TUs

In Gujarat, the following IEC activities were being undertaken:

- TV spots were being telecast on Gujarati TV channel Prasar Bharti to create awareness about DOTS services.
- Radio jingles were broadcast on radio channel Radio Mirchi, and TV spots were telecast on ETV and ZEE Gujarati to create awareness about DOTS.
- Innovative IEC material like scooter spare wheel cover was distributed across districts.
- Scrolling boards showing the message of DOTS were displayed at district tuberculosis centers (DTCs), civil hospitals, and the state medical college.
- Gujarati-language copies of "Booklet for Anganwadi Workers" were circulated at the grassroots level throughout the state.
- Scouts carried out a TB awareness campaign at railway stations.

It was observed in all five states that the majority of ACSM activities were undertaken during World TB Day on March 24th. A fresh set of posters and flexi banners were made and a number of activities were organized to create awareness about the TB programs under the RNTCP, highlighting the achievement of the previous year. The events organized on this day included: painting competitions, school activities, and rallies/functions, to which VIPs are invited and prizes distributed. Miking (public announcements) is done in cities.

Glimpses of World TB Day (March 24, 2012) in Gujarat

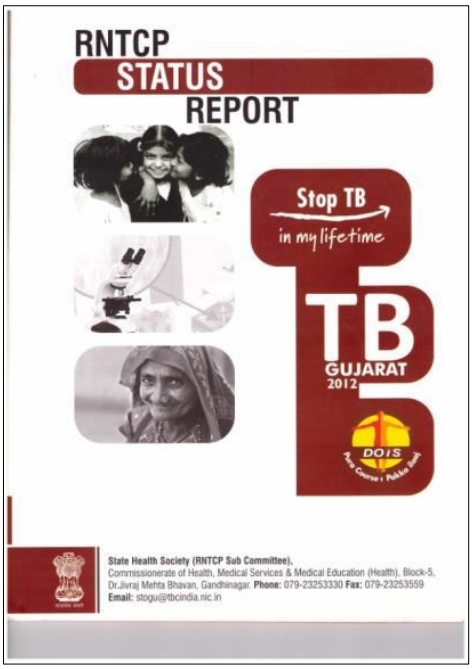
The district TUs organized ACSM activities at their own level. In addition to the material received from the center and state headquarters, the district units produced IEC materials in local languages and dialects and organized a number of ACSM activities. Tumkur district, Karnataka, and Surender Nagar district, Gujarat, were particularly active in this regard. They not only organized many ACSM activities but also documented them. For example, Tumkur published a quarterly RNTCP performance report that provided details on different performance indicators, including ACSM/IEC activities. Vishwa, the partner NGO, carefully documented all the ACSM activities in a photo album with dates. Table 3 gives a listing of TU ACSM activities in Tumkur district.

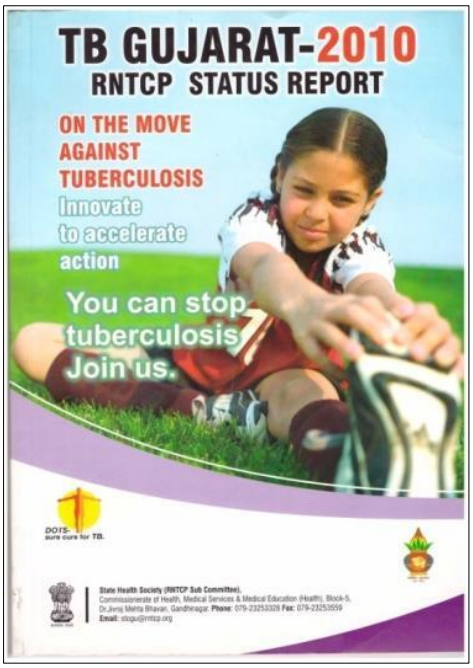
Table 3. Tumkur – TU IEC Activities in the Fourth Quarter 2012

Reference: RNTCP Performance Report: Tumkur – Fourth Quarter 2012, page 14

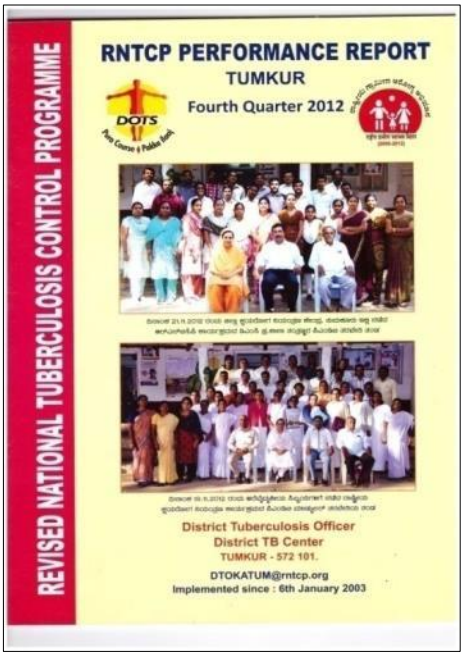
S. No.	TU Name	TB patient–providers meeting	Community meetings	School programs	Awareness programs	Sensitization meetings
1.	Tumkur	37	26	190	1	1
2.	Sira	41	37	136	2	1
3.	Pavagada	27	16	143	4	3
4.	Kunigal	35	60	142	0	3
5.	Tipyur	22	76	130	1	2
6.	Koratagere	20	13	49	3	1
	District Total	**182**	**228**	**790**	**11**	**11**

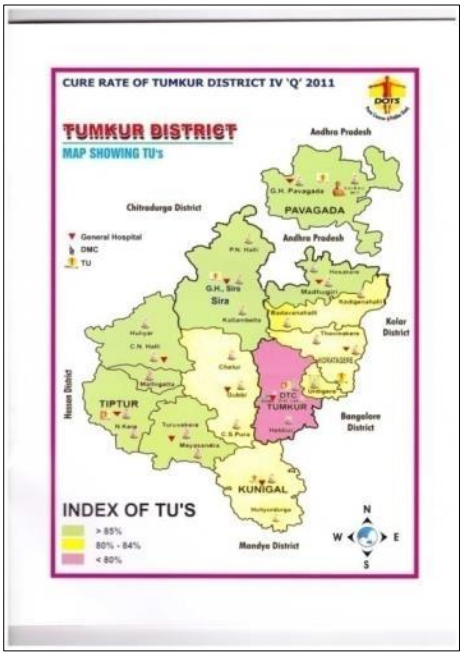
Source: RNTCP Annual Reports.



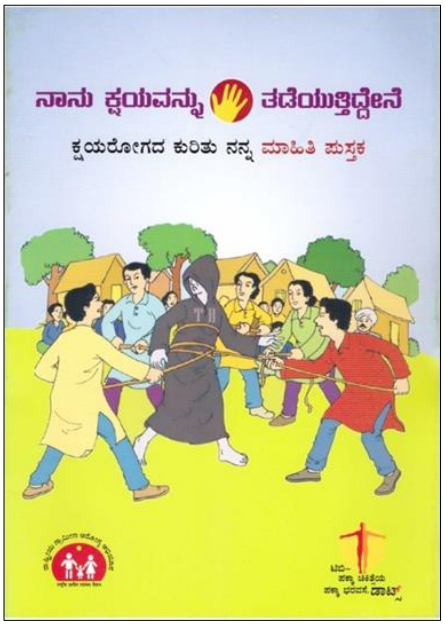


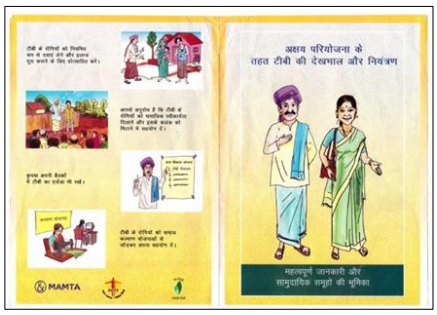
Tumkur District, Karnataka: Well-Documented Performance Report





Pictorial booklets and folders are designed centrally and distributed to the states for production in local languages. These are distributed widely to patients for information and also circulated for use by patient counselors and other service providers. Some specimen copies are shown below.





3.5 Social Mobilization

3.5.1 Social Mobilization to Build Partnerships

Social mobilization is the process of bringing together different sections of the targeted population, e.g., a village community or a ward or other small groupings, to raise awareness of and demand for a service, in this case the TB program. The emphasis here is on community participation and involvement in case detection and treatment.

Under the RNTCP, the partner NGOs play an important role in social/community mobilization to generate dialogue, negotiation, and consensus. The aim is to engage a range of players in interrelated and complementary efforts, while taking into account the needs of people. Social and community mobilization, integrated with other communication approaches, has been a key feature in numerous communication efforts worldwide. The polio eradication campaign in UP is a success story in social mobilization.

Social mobilization activities include group and community meetings, school activities, traditional media group performances, rallies, road shows, and home visits. IPC and group communication are the main channels of communication for disseminating TB-related key messages. Leaflets, posters,

pamphlets, videos, and other communication aids in local languages/dialects are often used to make communication contextual, easy, and comprehensible to the local community. Media materials like leaflets and pamphlets are often given to take home for repeated exposure.

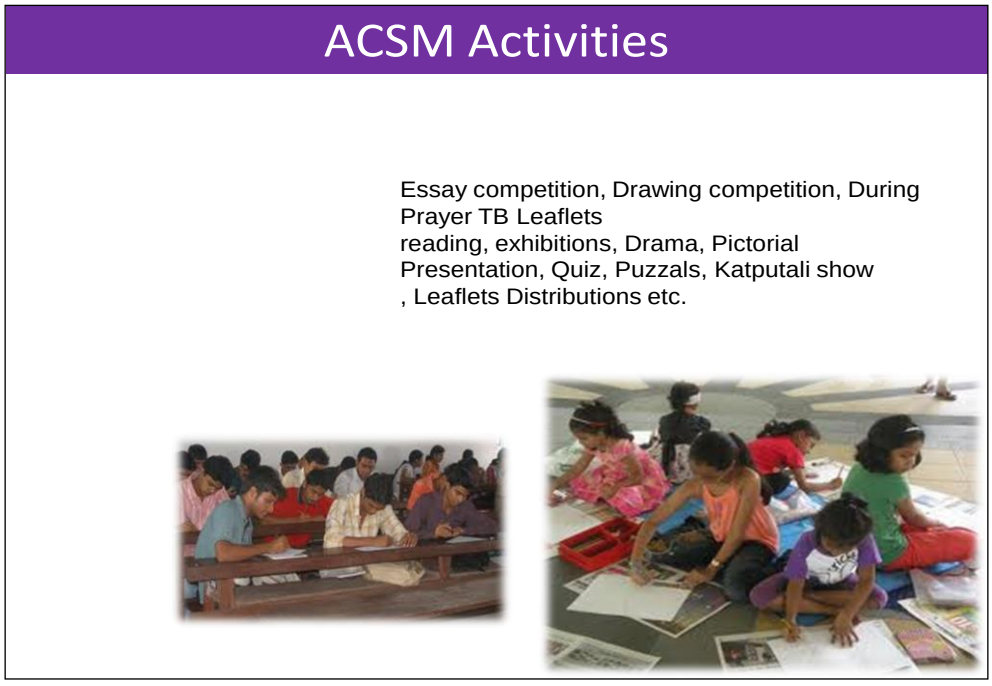
A noteworthy suggestion was made during an FGD in Begusarai district, Bihar. The suggestion was that the program teams going to a village for community mobilization be provided with a dress that makes the person wearing it look like the TB program logo. It may look a bit funny, but would go a long way toward drawing the attention of everyone in the community and establishing the brand of the program, thereby contributing to its success. In addition, the team should be provided a megaphone (hand-held loudspeaker) to increase its reach and efficacy.

In each of the states, at least one NGO has partnered with the state RNTCP unit. However, the partner NGO covered only a given number of districts in the states. In areas where there are many NGOs working with the program, a mother NGO coordinated and associated with other local NGOs in consultation with the state and district RNTCP units.

The efficacy of social mobilization efforts and patient-provider meetings largely depends on the communication skills of the NGO team and the service providers. Developing soft skills of all the field staff involved in the TB control program under the RNTCP, in such areas as IPC skills, group dynamics/communication skills, and counseling skills, would go a long way in making the program a success.

3.5.2 School Activities

In 2012, CTD directed all states to conduct TB awareness campaigns in schools, but did not provide any additional funds for the purpose. Despite complaining about the lack of funds, all states claim to have conducted some activities, like informing schoolchildren about TB and its symptoms, with the help of posters and banners. On being asked whether any cases came to their notice (for diagnosis) after the students may have shared the information about TB with their family and friends, the answer was a uniform "no" everywhere.



One of the respondents mentioned that the task of conducting school ACSM activities without additional budget and manpower was an ambitious and difficult activity. This situation hints at the target-based approach adopted for ACSM activities and the lack of a systematic approach to measure its outcome.

On being further probed about the efficacy of school activities, most officials and partner NGOs were of the view that the "school campaign" could be effective if it was done with proper time, planning, and financial support. School ACSM activities could indeed be quite effective if planned well and executed with the full involvement of teachers through the education department. The country's young can play an important role in generating awareness in their homes and neighborhoods and removing the stigma associated with TB.

3.6 ACSM with Program Implementers

The aim of ACSM under the RNTCP is to generate demand for quality diagnosis and treatment for TB, including attention to MDR TB and TB/HIV co-infection. The goal of ACSM is to support TB control efforts by:

- Mobilizing political commitment and resources for TB
- Improving case detection and treatment adherence
- Widening the reach of services
- Combating stigma and discrimination
- Empowering people affected by TB and the community at large

It may be noted that ACSM activities are not an end in themselves, but the means to increase case detection, DOTS adherence, and effective implementation of the TB control program in India.

To achieve the abovementioned objectives, the RNTCP has put in place a well-defined communication strategy that clearly states communication needs (objectives); target audiences and communication channels; and activities (communication tools), roles, and responsibilities at each level, that is, center, state, and district. The program encourages need-based ACSM strategy planning and implementation. The NGO partners undertake different ACSM activities under the RNTCP that aim to:

- Create awareness among people about the disease (signs and symptoms), diagnosis, and treatment so that accessibility and utilization of services can be increased

To this end, besides celebrating World TB Day, the NGO partners regularly hold village/community meetings throughout the year, based on their norms and targets. In our discussions with the NGO partner representatives, they usually claimed to have conducted the number of village meetings required as per norms. For instance, in Gujarat's Surender Nagar district, CBCI is associated with the RNTCP TB control program. It has been working in the district for more than 25 years in health, women's empowerment, and non-formal education, and has thus established a good rapport with the local people. As part of its other health activities, the CBCI team holds village meetings and creates awareness about TB as well. It also serves as a DOTS provider and helps with sputum collection and transportation from remote and distant villages to the DMCs.

According to the CBCI representative we met, the key to success in creating awareness about TB and mobilizing the community is the rapport and the credibility of the person and the organization. The goal is to:

- Motivate all care providers to provide standardized diagnostic and treatment services to all TB patients in a patient-friendly environment as per their convenience

The RNTCP can provide training and skill development of staff at all levels. As such, there is a training schedule for medical, technical, and soft skills. Partner NGOs are given the responsibility for conducting these skill development workshops. For instance, MAMTA has organized a series of soft skills development workshops for rural health care providers/TB care providers/DOTS providers in Bihar. The core subjects of these trainings include effective communication, team formation and functioning, and counseling.

The RNTCP's success also depends on the engagement of private health practitioners (the so-called *jholla chhap*/*Bengali doctors*) and other providers of health services that follow different systems of medicine. It was frequently mentioned during the course of our discussions in all five states that these private health practitioners are the first level of contact for most people, especially for those from the poorer sections of society. Their treatment may provide initial relief to TB patients but do not usually cure TB, as they do not follow the rigorous DOTS regime and give fewer medicines. Instead of the DOTS regime of a "handful of medicines" on alternate days along with injections, which cause reactions like acidity and "heat" that many patients find difficult to "digest" and "bear," these private practitioners give more bearable, but ultimately less effective, daily doses. Due to the reactions DOTS medicines cause in some people, some patients stop using DOTS and switch to private practitioners. In addition, patients are much more comfortable with private doctors and health care providers than with government doctors and providers. The government health facilities are also difficult to access due to the non-availability of staff, even during normal working hours. People leave early for work and return late in the evening, by which time the government facilities have closed.

Involvement of private practitioners is a must for the success of the RNTCP. A recent government order making the "notification of all TB cases" compulsory in the country has put an additional burden of compliance. Often private practitioners do not refer symptomatic TB suspect cases to the concerned RNTCP diagnosis facilities, possibly because doing so affects their business and income.

Appropriate schemes must be devised to compensate private practitioners for notifying TB suspects and/or treating TB patients with DOTS. If such a scheme was already there, it was not known or understood by the few private practitioners we met. In Meghalaya, the state TU organized a private practitioners' meet one evening to sensitize them on TB. Of the 40 invitees, only 4–5 doctors attended, and they expressed their misgivings about its relevance for them and the difficulties they would encounter in completing the notification formalities in the absence of computers and secretarial staff.

- Mobilize communities to engage in TB care, and to increase the ownership of the program by the community.

At the village meetings that are organized, 1–2 participants are encouraged to volunteer as *TB mitras.* They are required to continue generating awareness in the village and advise all those with a cough that has lasted longer than two weeks to go for checkup and diagnosis at DMCs.

Community involvement and ownership of the TB control program can significantly contribute to increased case detection and DOTS adherence for complete cure, but it takes:

- Advocacy to influence policy changes and sustain political and financial commitment.

In Gujarat, advocacy with the Reliance Group of industries led to organization of TB awareness camps for their employees at Rajkot and Junagarh. The camps were organized with Reliance's support and funding.

In another case, advocacy with the Municipal Corporation of Surat resulted in organization of awareness and a testing camp for high-risk workers in the gems industry.

3.7 Monitoring and Evaluation

There are well-designed systems, procedures, and templates for M&E of the medical and technical aspects of the RNTCP. However, such monitoring rigor is absent for ACSM activities.

During the course of field study, we asked the concerned officials and others associated with ACSM implementation about the impact of ACSM activities and the mechanisms for assessing their efficacy. The responses were couched in general terms; ACSM activities led to greater awareness among people. When asked whether there was any increase in case detection or more foot traffic at DMCs for diagnosis after any ACSM event or activity, say within a fortnight or a month, no data were available. Going forward, it would be useful to devise appropriate mechanisms and templates to capture this information and maintain the data.

3.8 Promising Practices to Support ACSM

SETCOM – Direct link with frontline workers and the community. In Gujarat, on the third Thursday of every month, between 2pm and 4pm, more than 6,000 villages are reached via direct link SETCOM. On average, 36,000 ASHAs/health workers/AWWs/members of Village Health and Sanitation Committees are provided technical information on select issues by subject specialists, covering topics like TB, malaria, tobacco, maternal health, school health, and family welfare. State-level program managers address frontline workers and minimize their doubts in question-and-answer sessions.

ACSM activities in Gujarat are supported by the Health Education Bureau, which helps in addressing the problem of low budget and timely availability of resources for ACSM activities. This is a good approach to strengthen coordination with NRHM.

Gujarat has adopted the practice of signing an MOU with a local NGO to hire Communication Facilitators; this helps fill the position quickly in the case of contractual staff turnover.

Gujarat uses online free messaging services of Way2SMS to report the MDR TB patients diagnosed in six districts. Though the service is currently operating on a pilot basis and is used for CBNAAT diagnostic technology, it promises good results and could be used in referral and diagnosis of normal TB cases as well.

Live interaction SETCOM program with ASHAs and local elected Panchayat member during March 24th World TB Day.

3.9 The Way Forward

The emergence of MDR TB and TB/HIV co-infection and increasing diabetic cases are posing new and serious challenges for the RNTCP. The program needs a paradigm shift in the coming years. It should make strategic plans for providing universal access, that is, detect at least 90 percent of all types of TB cases and ensure successful treatment of at least 90 percent new cases and at least 85 percent of previously treated cases.

The revised national TB/HIV framework envisages that RNTCP and National AIDS Control Programme IEC materials, specifically pictorial IEC on symptoms of TB and cough hygiene, be displayed at all HIV and TB care settings to provide education, care, and support to people living with HIV (PLHIV) and TB patients. The scope for strengthening this collaboration has been identified in the ACSM strategy.

The primary focus of ACSM activities would likely shift to prevent the emergence of MDR TB by ensuring good adherence to the DOTS regime through effective communication with and counseling of TB patients. Advocacy and capacity development of care providers by improving their motivation and counseling skills will go a long way in controlling and curing TB in the country.

The role of ACSM is more challenging in newer initiatives and focus areas of the program, such as MDR TB and TB/HIV. These patients have to undergo treatment for a longer duration and with more toxic drugs, including injections. Moreover, most of these patients have a previous history of default, which can diminish motivation to complete treatment. Added to these issues is the stigma and discrimination faced at the hands of family and society.

Wider mass awareness and education on cough hygiene and disposal of sputum (covering nose and face while sneezing/coughing and not spitting indiscriminately in public) are crucial to check the spread of TB infection.

Some approaches to work toward these goals could be:

1. Involve communication specialists to strengthen and lead ACSM strategic planning at national and state levels, provide support across the RNTCP network, and work closely with NRHM communication stakeholders
2. Focus ACSM planning format on state and district-level priorities and use output/outcome monitoring indicators for different ACSM activities
3. Concentrate on achieving universal awareness on the right to and availability of free TB treatment and care through mass media and mid-media
4. Strengthen social mobilization for TB detection and DOTS adherence through PRIs and other community-based organizations like community self-help groups and Village Health and Sanitation Committees
5. Prioritize IPC approaches at the TU level and below; enhance provider communication targeted at different categories of patients so that the right person gets the right message at the right time

References

Bergstrom, Karin et al. 2009. *Joint Monitoring Mission: Revised National Tuberculosis Control Programme, India.* http://www.tbcindia.nic.in/Pdfs/JMM-Report-2009.pdf.

Chaturvedi, Gitanjali. 2009. *The Vital Drop: Communication for Polio Eradication in India.* Sage Publication.

CTD. 2012. *TB India 2012 – Revised National TB Control Programme: Annual Status Report.* http://tbcindia.nic.in/pdfs/TB%20India%202012-%20Annual%20Report.pdf.

Gupta, Deepak. 2011. *Are We There Yet: Chasing the Polio Virus.* India: Indian Association of Parliamentarians on Population & Development.

National Institute of Environmental Health Sciences. n.d. "Strategic Plan (2012–2017) – Advancing Science, Improving Health: A Plan for Environmental Health Research." http://www.niehs.nih.gov/about/strategicplan/strategicplan2012_508.pdf.

Project Axshya. n.d. "A civil society initiative to strengthen TB care and control in India." http://www.axshya-theunion.org/.

RNTCP. 2013. *Annual Status Report.* http://www.tbcindia.nic.in/pdfs/tb%20india%202013.pdf

WHO. 2012. *Global Tuberculosis Report.* http://www.who.int/tb/publications/global_report/gtbr12_main.pdf.

———. 2006. Advocacy, Communication and Social Mobilization to Fight TB: A 10-Year Framework for Action." http://whqlibdoc.who.int/publications/2006/9241594276_eng.pdf.

WHO/India. Core Programme Clusters: Communicable Diseases and Disease Surveillance – Tuberculosis. http://www.who.int/countries/ind/en/

Annex 1. Field Visit Team Members List

S. No.	State	District	Dates	Field team
1.	Gujarat	Surendranagar	24–28 February	Dr. J.S. Yadav Mr. Shiva Shrestha
2.	Bihar	Begusarai	3–7 March	Dr. J.S. Yadav Mr. Sumit Asthana
3.	Uttar Pradesh	Azamgarh	10–16 March	Dr. J.S. Yadav Mr. Sumit Asthana
4.	Karnataka	Tumkur Davangere	7–12 April	Dr. J.S. Yadav Mr. Maju Mathew
5.	Meghalaya	Nongstoin	14–20 April	Dr. J.S. Yadav Mr. Sumit Asthana Ms. Beth Haytmanek

Annex 2. Study Team Interactions: List of Officials

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